DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G062	A. BUILDING _____ B. WING _____	08/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	6300 9TH STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An recertification survey was conducted from August 3, 2010, through August 5, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of six females with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with clients and staff, and the review of clinical and administrative records, including incident reports.	W 000	Received 8/26/10 DOH-HCQA-ICFD	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure outside services met the needs of one of three clients in the sample. (Client #2) The findings include: On August 3, 2010 at 12:28 p.m., discussion with the day program case manager and the review of Client #2's attendance records revealed that she had not attended the day program since she was admitted on November 11, 2009. The case manager indicated that when the client rode the van to the day program, she went out to the van and tried various methods to encourage the her to enter the building, however, the client refused to exit the van. According to the case manager, if the client exited the van and entered the day	W 120	All staff will be trained on individual #2's IPP goal on attending the day program. The management team will review IPP documentation weekly and staff will receive on-going training on documentation for all IPP goals.	8/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese - Program Director | TITLE | (X6) DATE: 8/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 program, it would be documented. On August 4, 2010 at 4:00 p.m., the review of the client's IPP revealed a goal which stated that Client #2 "will attend her day program one day a week with verbal prompts, gestures and reinforcement for three consecutive months. At the time of the survey, however, there was no evidence the day program reinforcement efforts to get the client to enter the day program when she arrived on the van, had been documented.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of three clients included in the sample. (Client #2) The finding includes: During the entrance conference on August 3, 2010, beginning at approximately 8:30 a.m., the qualified mental retardation professional (QMRP) and residential manager (RM) indicated that the	W 124	The QMRP/ Residential Manager will ensure that consent from guardians/ advocates is obtained before any individual receives sedation or when any issue arises regarding restriction of their rights. The Human Rights Committee will monitor for compliance by QMRP/ Residential Manager.	8/23/10

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W 124	Continued From page 2 Client #2 had sister who assisted with making health care decisions. On August 4, 2010, at approximately 12:20 p.m., review of Client #2's medical records revealed a physician's order dated July 2010, for Ativan 2 mg by mouth one hour prior to her dental appointment. Interview with the QMRP on the same day approximately 12:40 p.m. confirmed that the sedation was given on July 6, 2010. Review of Client #2's Psychological Assessment dated October 2010, on August 4, 2010, at approximately 1:20 p.m., revealed the client was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of Client #2's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication. At approximately 1:35 p.m., the QMRP acknowledged that she had not obtained consent from Client #2's sister prior to the administration of Ativan.	W 124		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident for one of three clients included in the sample. (Client #1)	W 156	The serious reportable investigation form will be amended to include a signature line for the administrator.	8/23/10

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W 156	Continued From page 3 The finding includes: On August 5, 2010, at approximately 2:20 p.m., interview with the qualified mental retardation professional (QMRP) and review of the facility's incident report dated June 19, 2010 and corresponding investigative report dated June 20, 2010 revealed Client #1 indicated to the Licensed Practical Nurse (LPN) that she had pain in her abdomen. The LPN immediately notified the Registered Nurse (RN) who instructed the LPN to evaluate Client #1. Upon her evaluation, the LPN determined that Client #1's abdomen was distended and tight. The primary care physician ordered for Client #1 to be transported to the emergency room via the facility's transportation. Client #1 was admitted into the hospital on June 20, 2010 and discharged on June 20, 2010. She was diagnosed with a partial small bowel obstruction. Further review of the corresponding investigative report revealed that the QMRP (Investigator) and Incident Management Coordinator (IMC) completed and signed the investigation on June 29, 2010. However, there was no written evidence that the results of the investigation were reviewed by the administrator within five working days. Interview with the QMRP and Residential Manager on August 5, 2010, at approximately 2:55 p.m., acknowledged that the administrator had not signed the final results of the investigation.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

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W 159	Continued From page 4 Integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's qualified mental retardation professional failed to coordinate, integrate, and monitor services for three of three clients in the sample. (Clients #1, #2, and #3) The finding include: 1. On August 3, 2010, at 8:20 a.m., interview with the direct support staff revealed that the client had been enrolled at a new day program since 2009, however had always refused to enter the building. During the entrance conference on August 3, 2010, at 9:37 a.m., the qualified mental retardation professional (QMRP) confirmed the staff statements concerning Client #2's day program attendance. Further discussion with the QMRP revealed that in 2010, the interdisciplinary team had recommended various strategies which had been attempted to encourage the client to attend her day program, however these efforts had been futile. [Cross refer to W120]. Record review on August 3, 2010, at 12:28 p.m., revealed Client #2 was admitted to the day program on November 11, 2009, however had never attended the program. According to the QMRP, since the client's admission to the day program, she had usually refused to leave the group home. Various strategies had been attempted by group home and the day program staff to encourage the	W 159		

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W 159	Continued From page 5 client's attendance, however she continues to refuse to exit the van upon arrival at the day program. On August 5, 2020, beginning at 12:39 p.m., continued discussion with the QMRP concerning Client #2 revealed that due to the client's failure to attend her day program, and the complexity of the situation, she further sought the assistance of the IDT to identify more effective strategies. Record review on August 5, 2010 at 12:45 p.m., revealed the following information regarding efforts to address Client #2's concerns: (1) On January 28, 2010, Client #2 was assessed at the group home by an independent consulting psychologist, who had been recommended by the facility's consulting behavioral specialist. According to the QMRP, the psychologist presented his recommendations at a case conference held at the group home on March 17, 2010. Review of the case conference notes and recommendations revealed the following : a. "Exhibits characteristics of autism." - Develop a program for taking her to the day program. Make it visual. - Explore visual communication strategies. Use pictures to show her what she will be doing (picture of van, van seat, day program). -Possible speech and language evaluation with more recommendations. On August 5, 2010 at 1:55 p.m., interview with the QMRP and record review revealed that on June	W 159	a. The communication book will be revised to include pictures that address Individual #2's day program attendance and activities during the day. QMRP/ Residential Manager will monitor implementation of scheduled activites.	9/03/10

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W 159	Continued From page 6 29, 2010, the speech and language pathologist (SLP) brought Client #2 a picture book and reviewed it with her one on one staff on duty. On August 5, 2010 at 2:02 p.m., the review of the picture book, which was confirmed by the QMRP, revealed that it did not include the recommended pictures of the van, van seat, and the day program. -She should have a pattern that she needs to follow. -Randomly attempt to take her on the van one day a week. [Cross refer to W252]. Interview with the QMRP on August 5, 2010, at 2:40 p.m., revealed that the client's tolerance of attempts to take her to the day program should be documented on the Antecedent Behavior Consequence (ABC) data collection form. The subsequent review of the ABC data collection form revealed that it was not designed to accurately monitor the client's performance in the objective, as written. The review of the client's Individual program plan (IPP) however, revealed an objective had been developed to include seven steps. Although interview with the QMRP, the home manager, and the client's one on one direct support staff verbalized these steps, consistent program documentation was not available, as evidence of its implementation. -Team should reevaluate the use of a helmet. -Set up an appointment with the ophthalmologist to evaluate the use of the helmet. [Cross refer to W262]. On August 5, 2010 at 2: 25 p.m., a discussion with the QMRP revealed the nurse indicated that the use of the protective	W 159	The Behavior Specialist developed a new form that specifically addresses steps that Individual #2 should take to attend her day program. All staff will be trained on the new document. An appointment was made for Individual #2 to be evaluated by her ophthalmologist for helmet use. In the future, the management team will review all recommendations and address them in a timely manner.	8/27/10 9/10/10

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W 159	Continued From page 7 helmet may have been initially recommended by the ophthalmologist, to prevent self injurious behavior. Further interview with the QMRP, and the subsequent record review on August 5, 2010, at 2:40 p.m., revealed that available records did specify when and why the helmet was initially recommended. The record further revealed that the client's ophthalmology consultation reports dated April 12, 2010 and May 5, 2010, did not include a request for an assessment of the client to determine if the use of a helmet continued to be warranted. b. Interview with the QMRP on August 5, 2010, at 1:04 p.m., had also revealed that after the case conference was held on March 17, 2010 for Client #2, the behavioral specialist recommended a second opinion regarding the "autistic features." According to the QMRP, on May 10, 2010, a second psychologist conducted a behavioral observation of Client #2 for approximately thirty minutes at the group home. The QMRP indicated that the second psychologist concurred with the previous psychologist that the client exhibited "autistic characteristics." Continued discussion with the QMRP, however revealed the report of this observation had not been provided for the client's record. c. Continued interview with the QMRP on August 5, 2010, at 1:11 p.m., revealed that after the second psychologist diagnosed that Client #2 exhibited "autistic features", the behavioral specialist deemed it beneficial to conduct an updated psychological assessment and an updated behavior support plan. On August 5, 2010, at 3:15 p.m., the record revealed the most current behavior support plan (BSP) was dated October 31, 2009 and the psychological	W 159	b. A copy of the assessment done by the second psychologist was provided by the Behavior Specialist to the QMRP. c. An updated Behavior Support Plan and psychological assessment was provided by the Behavior Specialist with the recommended updates.	8/25/10 8/26/10

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W 159	Continued From page 8 assessment was dated January 6, 2010. At the time of the survey, the updated BSP and psychological assessment had not be provided. At the time of the survey, there was no evidence that services recommended during Client #2's March 17, 2010 case conference had been coordinated timely by the facility's QMRP, to ensure their implementation for the client. 2. The QMRP failed to ensure Client #1's individual program plan (IPP) included training in activities of dental hygiene. (See W242) 3. The QMRP failed to ensure continuous active treatment in recommended self-medication training objectives for Clients #1, #2 and #3. (See W249.1) 4. The QMRP failed to ensure continuous active treatment for the implementation of strategies identified in Client #1's IPP which were designed to increase her tolerance of her hearing aid. (See W249.2)	W 159	2. Cross reference W242	8/9/10
			3. Cross reference W249.1	8/30/10
			4. Cross reference W249.2	8/30/10
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record	W 242		

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W 242	Continued From page 9 review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for one of the three clients in the sample. (Client #1) The finding includes: Review of Client #1's medical record on August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the client brush her teeth two (2) times a day. Continued review of the client's record revealed the client had full mouth scaling and prophylaxis completed during the dental appointment. Review of Client #1's Individual Program Plan (IPP) dated August 2010, at approximately 9:12 a.m., revealed no evidence of a training program to address the client's oral hygiene. Review of the qualified mental retardation professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximately 9:15 a.m., revealed Client #1's tooth brushing program was being implemented twice daily. During interview with the QMRP on August 4, 2010, at approximately 9:20 a.m.; however, revealed that Client #1 did not have a training program to address her dental hygiene. There was no evidence the facility ensured the client's IPP included training in activities of dental hygiene.	W 242	An IPP goal was put in place for individual #1 to be encouraged to brush her teeth twice daily. The QMRP will monitor all recommendations from Medical Consultants to ensure that they are edressed appropriately and in a timely manner.	8/9/10
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 10 each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure client's received continuous active treatment, for three of the three clients included in the sample. (Clients #1, #2 and #3) The findings include: 1. During medication administration observation on August 4, 2010, at 7:25 a.m., revealed Registered Nurse #1 (RN #1) punched out all of Client #1's medications from the blister pack. The RN placed the cup of medications into Client #1's hands in order for the client to consume the medications with one (1) physical prompt. Further observation revealed the RN poured a cup of water for Client #1 who then was able to pick up the cup and consume the contents with two (2) verbal prompts. During a face-to-face interview with RN #1 on August 4, 2010, at approximately 7:30 a.m., revealed Client #1 had a self-medication program however, the program was implemented in the evening. Review of Client #1's self-medication program dated August, 2010, on August 4, 2010, at	W 249	1. The nursing staff will receive training on Self -Medication Administration Program. In the future, the individuals will have the opportunity to participate in self-medication administration to the best of their ability.	8/30/10

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W 249	Continued From page 11 approximately 8:30 a.m., revealed that staff was to document at least three times per week (M-W-F) if the client was able to perform the following steps during the medication administration. Further review revealed the self-medication program was as follows: a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from blister pack; d. Proper disposal of used medication cup; e. Instill eye drops and f. Put cup in kitchen sink after taking all medications There was no evidence that the client was given the opportunity to fully participate in the self-medication program. 2. During medication administration observation on August 4, 2010, at 7:55 a.m., revealed RN #1 crushed and mixed Client #2's medication in applesauce than spoon-fed the cup of medications to Client #2. Further observation revealed the RN poured a cup of water for Client #2 who then was able to pick up the cup and consume the contents with one (1) verbal prompt. During a face-to-face interview with RN #1 on August 4, 2010, at approximately 7:31 a.m., revealed Client #2 had a self-medication program however, the program was implemented in the evening. Review of Client #2's self-medication program dated August, 2010, on August 4, 2010, at approxdmately 8:35 a.m., revealed that staff was	W 249	2. Indivduals will be given the opportunity to participate in the Medication Administration Program. Nursing staff will be instructed to review steps in the self-medication program.	8/30/10

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	09G082	A. BUILDING _____ B. WING _____	08/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	6300 9TH STREET NW WASHINGTON, DC 20011

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W 249	Continued From page 12 to document at least three times per week (M-W-F) if the client was able to perform the following steps during the medication administration. Further review revealed the self-medication program was as follows: a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from blister pack; d. Take medication with applesauce; e. Put cups in kitchen sink after taking all medications There was no evidence that the client was given the opportunity to fully participate in the self-medication program. 3. During medication administration observation on August 4, 2010, at 7:35 a.m., revealed RN #1 punched out all of Client #3's medications from the blister pack. The RN placed the cup of medications into Client #3's hands in order for the client to consume the medications with one (1) physical prompt. Further observation revealed the RN poured a cup of water for Client #3 who then was able to pick up the cup and consume the contents with two (2) verbal prompts. During a face-to-face interview with RN #1 on August 4, 2010, at approximately 7:40 a.m., revealed Client #3 had a self-medication program however, the program was implemented in the evening. Review of Client #3's self-medication program dated August, 2010, on August 4, 2010, at approximately 8:45 a.m., revealed that staff was	W 249	3. All steps within the self-medication program will be followed by the individuals with the assistance from nursing staff.	8/30/10

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W 249	Continued From page 13 to document at least three times per week (M-W-F) if the client was able to perform the following steps during the medication administration. Further review revealed the self-medication program was as follows: a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from blister pack; d. Proper disposal of used medication cup; f. Put cup in kitchen sink after taking all medications There was no evidence that the client was given the opportunity to fully participate in the self-medication program. 4. The facility failed to consistently implement strategies identified in Client #1's IPP designed to increase tolerance of her hearing aid during waking hours, as evidenced below: On August 3, 2010, at 10:48 a.m., observation at the day program revealed Client #1 walked over to the desk where the surveyor was sitting with the day program specialist. The program specialist signed the word [wave] and the client responding by waving [hi] to the surveyor. The day program specialist signed [thank you] and Client #1 responded by signing thank you back. At 4:07 p.m., evening observations at the home revealed direct care staff #1 signed the word [pretty] to Client #1 and she responded by signing the word pretty back to staff. At approximately 4:10 p.m., the house manager was observed to sign the word [wash hands] to Client #1 during snack time. Client #1 immediately went to the bathroom to wash her hands.	W 249	4. The staff will be trained to encourage individual #1 to wear her hearing aids during waking hours. In the future, the management team will frequently check the usage of individual #1's hearing aids and the staff will recieve on-going training.	9/10/10

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W 249	Continued From page 14 On August 3, 2010, at approximately 5:15 p.m., interview with direct care staff #1 revealed that she signed to Client #1 because she was deaf. Further interview revealed that Client #1 had a hearing aid to assist her with hearing. This was also acknowledged through interview with the House Manager on August 4, 2010, at approximately 11:30 a.m. On August 4, 2010, at approximately 9:50 a.m., review of Client #1's current physician orders dated July 2010 revealed the client had a diagnosis of bilateral hearing loss. Interview with the qualified mental retardation professional (QMRP) and review of Client #1's individual Support Plan (ISP) dated January 4, 2010 on the same day at approximately 12:15 p.m., revealed an objective for the client to tolerate her hearing aid during waking hours 100% of trials daily. Observations the previous day (August 3, 2010), however, revealed that Client #1 was not observed wearing her hearing aid at the day program and at her home.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on an individual Program Plan (IPP) objective, for one of three	W 252	Cross reference W120	8/27/10

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W 252	Continued From page 15 clients in the sample. (Client #2) Tha finding include: [Cross refer to W120]. The facility failed to ensure that data was consistently maintained on the training objective designed to increase Client #2's day program attendance, as evidenced below: Interview with the home manager and the qualified mental retardation professional (QMRP) on August 3, 2010 during the entrance conference at 9:30 a.m.,revealed Client #2 had been refusing to attend her day program for sometime. Further discussion with the QMRP, home manager, and one on one support staff indicated that if the client went to the day program, she refused to get off the van. Interview with both the QMRP and the home manager revealed that a training objective had been developed to monitor the client's progress on attending the day program. The home manager indicated that staff had been practicing the steps of the training objectives to encourage the client to attend her day program. According to staff, attempts were made to implement the steps of the objective, however, the client was usually non-compliant. On August 4, 2010 at 4:00 p.m., the review of the client's IPP revealed a goal which stated that she "will attend her day program one day a week with verbal prompts, gestures and reinforcement for three consecutive months. The review of the in home objective revealed the client "will be encouraged by her one on one to attend her day program at least one day a week. "She will practice" the steps:	W 252		

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W 252	Continued From page 16 (1) Put on coat and jacket (2) Get back pack from closet (3) Walk to the back door (4) Exit the back door (5) Walk to the van (6) Get on the van (7) Get off the van at the day program On August 5, 2010 at 1:37 p.m., record review revealed data collection on the practice steps on May 25, June 22, and August 3, 2010. At the time of the survey, there was no evidence data on Client #2's training objective designed to increase her day program attendance, had been collected at the frequency required to accurately monitor her progress.	W 252		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for one of the three clients in the sample. (Client #2) The finding includes: On August 3, 2010, observations from 11:58 a.m. to 5:10 p.m., revealed Client #2 was observed to wear her safety helmet two times at (4:10 p.m.	W 262	Individual #2's helmet use will be reviewed by the Human Rights Committee at the next scheduled meeting. In the future, all restrictive devices will be reviewed by the HRC at least annually.	9/7/10

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W 262	Continued From page 17 and 4:42 p.m.). Interview with the facility's qualified mental retardation professional (QMRP) on August 5, 2010 at 2:27 p.m., revealed that the protective helmet was prescribed by the eye doctor due to the client's right eye blindness. According to the QMRP, her discussion with the nurse in the past had revealed that the use of the protective helmet had been initially recommended by the ophthalmologist. Review of the current physician's orders dated July 2010 on August 5, 2010, at approximately 10:00 a.m., revealed under the section "safety orders", a protective helmet to be worn during waking hours. On August 5, 2010, at approximately 3:30 p.m., review of the facility's Human Rights Committee (HRC) minutes from May 9, 2010 to June 7, 2010, revealed that the HRC had not reviewed and/or discussed the use of Client #2's protective helmet. This was acknowledged through interview with the House Manager on the same day at approximately 3:45 p.m.	W 262		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to ensure health services as prescribed for one of three clients in the sample.(Client #3) The finding includes:	W 331		

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W 331	Continued From page 18 On August 3, 2010, at 7:35 a.m., Client #3 was observed to receive Hydrochlorothiazide 12.5 mg, 1 capsule. During this time, the client was initially resistive to having her blood pressure taken by the nurse. With encouragement, however, the client was able to remain still for her blood pressure (BP) assessment. On August 3, 2010, at 7:39 a.m., interview with the nurse administering the medication revealed that Client #3's intermittent refusal and/or failure to remain still for blood pressure assessment had been an ongoing concern. The nurse also stated the client was prescribed a Clonidine Patch, 6.3 mg, to be applied to an area on her body once a week. Additionally, the nurse indicated that the primary care physician (PCP) prescribed that the client's blood pressure be monitored twice a day. The subsequent review of the client's record at 8:37 a.m. confirmed the physician's orders for the aforementioned medication. A physician's order dated April 10, 2010, prescribed that Client #3's blood pressure be assessed and documented twice daily. On August 4, 2010 at 11:42 a.m., record review revealed no blood pressure was documented for Client #3's at six of the scheduled times in May 2010. Although the previous interview with the nurse had indicated that the client sometimes failed to remain still and/or refused, there was no evidence the reason why the client's blood pressure was not assessed and/or documented on three (May 10, 7, and 13, 2010) of the six dates. The June 2010 MAR revealed a similar finding of no evening BP readings on seven days (June 2, 7, 15,16,18, 23 and 24, 2010).	W 331	The nursing staff received additional training on documenting on medication administration record on 8/19/10. In the futura, the primary nurse will review medical records to ensure consistent and proper documentation for BP assessments. The Director of Nursing will review medical records on a monthly basis to ensure medical and nursing services are provided on time.	8/19/10

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W 331	Continued From page 19 At the time of the survey, there was no evidence nursing services had maintained consistent documentation of Client #3's evening blood pressure readings to ensure accurate monitoring of the effectiveness of her prescribed medications.	W 331		

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 3, 2010 through August 5, 2010. A random sample of three residents was selected from a population of six females with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with residents and staff, and the review of clinical and administrative records, including incident reports.	I 000		
I 075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that each bedroom was equipped with a night stand for each resident for three of six residents. (Resident's #1, #3, and #6) The finding includes: During the inspection of the environment on August 5, 2010, beginning at 10:30 a.m., the bedrooms of residents #1, #3 and #6 were observed to have no nightstands for the individuals. In an interview at the same time, the house manager (HM) acknowledged that the nightstands had not been provided for the residents' bedrooms. At the time of the survey, there was no evidence	I 075	Night stands will be purchased for individuals #, #3, and #6.	9/10/10

Courtney A. Reese Program Director 8/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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I 075	Continued From page 1 that each bedroom had been equipped with the minimum required items.	I 075		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the exterior of the GHMRP was maintained in a safe, orderly, and attractive manner for six of six residents in the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: An inspection of the environment was conducted on August 5, 2010, beginning at approximately 11:00 a.m. During the inspection, the surveyor was accompanied by the House Manager. The following concerns were identified: Exterior: 1. The front porch baseboard on the left side of the home evidenced mildew. 2. The front driveway had an elevated area, creating a potential trip hazard. 3. On the upper rear right side of the exterior wall, there was a noticeable hole which makes the exterior wall unattractive.	I 090	1. Mildew was removed from the left side of the home. 2. Front driveway will be repaired. 3. The holes will be repaired on the right side of the home.	8/6/10 9/10/10 9/10/10

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I 090	Continued From page 2 4. On the upper rear left side of the exterior wall there were unsightly rust spots. 5. The rear fire escape steps evidenced chipping and peeling paint on the tread. 6. The rear basement steps evidenced crumbling and broken cement on the tread which could be a potential trip hazard. Interior: The basement carpet has noticeable stains. The House Manager confirmed the findings on August 5, 2010 at 12:00 p.m.	I 090	4. The rust will be removed on rear left side of home. 5. The rear fire escape will be painted. 6. The steps will be repaired leading to the basement. Carpet will be removed and floor will be tiled.	9/10/10 9/10/10 9/10/10 9/10/10
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP's qualified mental retardation professional failed to coordinate, integrate, and monitor services for one of three residents in the sample. (Resident #2) The finding includes: On August 3, 2010 at 8:20 a.m., interview with the direct support staff at this time revealed that the resident had been enrolled at a new day program since 2009, however had always refused to enter the building. During the entrance conference on August 3,	I 180		

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I 180	Continued From page 3 2010 at 9:37 a.m., the qualified mental retardation professional (QMRP) confirmed the staff statements concerning Resident #2's day program attendance. Further discussion with the QMRP revealed that in 2010, the interdisciplinary team had recommended various strategies which had been attempted to encourage the resident to attend her day program, however these efforts had been futile. [Cross refer to W120]. Record review on August 3, 2010 at 12:28 p.m., revealed Resident #2 was admitted to the day program on November 11, 2009, however had never attended the program. According to the QMRP, since the resident's admission to the day program, she had usually refused to leave the group home. Although various strategies had been attempted by group home and the day program staff to encourage the resident, if the resident rode on the van, she refused to exit the van upon arrival at the day program. On August 5, 2020, beginning at 12:39 p.m., continued discussion with the QMRP concerning Resident #2 revealed that due to the resident's failure to attend her day program, and the complexity of the situation, she further sought the assistance of the IDT to identify more effective strategies. Record review on August 6, 2010, at 12:45 p.m., revealed the following information regarding efforts to address Resident #2's concerns: (1) On January 28, 2010, Resident #2 was assessed at the group home by an independent consulting psychologist, who had been the recommended by the GHMRP's consulting behavioral specialist. According to the QMRP,	I 180		

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I 160	Continued From page 4 the psychologist presented his recommendations at a case conference held at the group home on March 17, 2010. Review of the case conference notes and recommendations revealed thay included the following : a. "Exhibits characteristics of autism." - Develop a program for taking her to the day program. Make it visual. - Explore visual communication strategies. use pictures to show her what she will be doing (picture of van, van seat, day program). -Possible speech and language evaluation with more recommendations. On August 5, 2010 at 1:55 p.m., interview with the QMRP and record review revealed that on June 29, 2010, the speech and language pathologist (SLP) brought Resident #2 a picture book and reviewed it with her one on one staff on duty. On August 5, 2010, at 2:02 p.m., the review of the picture book, which was confirmed by the QMRP, revealed that it did not include the recommended pictures of the van, van seat, and the day program. -She should have a pattern that she needs to follow. - Randomly take attempt to take her on the van one day a week. [Cross refer to W252]. Interview with the QMRP on August 5, 2010, at 2:40 p.m. revealed that the resident's tolerance of attempts to take her to the day program should be documented on the abc data collection form. The subsequent review of the abc data collection form revealed that it was not designed to accurately monitor the resident's	I 160	Cross reference W159 Cross reference W159	9/03/10 9/03/10

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I 180	Continued From page 5 performance in the objective, as written. The review of the resident's individual program plan (IPP) however, revealed an individual program plan (IPP) objective had been developed and included seven steps. Although interview with the QMRP, the home manager, and the resident's one on one direct support staff verbalized these steps, consistent program documentation was available, as evidence of its implementation. -Team should reevaluate the use of a helmet. -Set up an appointment with the ophthalmologist to evaluate the use of the helmet. [Cross refer to W262]. On August 5, 2010 at 2: 25 p.m., interview with the QMRP indicated that it was thought that Resident #2's helmet may have been initially recommended by the ophthalmologist, to prevent self injurious behavior. Further interview with the QMRP, and the subsequent record review on August 5, 2010 at 2:40 p.m., revealed that available records did specify when and why the helmet was initially recommended. The record further revealed that the resident's ophthalmology consultation reports dated April 12, 2010 and May 5, 2010, did not include a request for an assessment of the resident to determine if the use of a helmet continued to be warranted. b. Interview with the QMRP on August 5, 2010 at 1:04 p.m. had also revealed that after the case conference was held on March 17, 2010 for Resident #2, the behavioral specialist recommended a second opinion regarding the "autistic features. " According to the QMRP, on May 10, 2010, a second psychologist conducted a behavioral observation of Resident #2 for approximately thirty minutes at the group home. The QMRP indicated that the second	I 180	Cross reference W159(a) Cross reference W159(b)	9/03/10 8/25/10

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I 180	Continued From page 6 psychologist concurred with the previous psychologist that the resident exhibited "autistic characteristics." Continued discussion with the QMRP, however revealed the report of this observation had been provided for the resident's record. c. Continued interview with the QMRP on August 5, 2010 at 1:11 p.m., revealed that after the second psychologist diagnosed Resident #2 exhibited "autistic features", the behavioral specialist deemed it beneficial to conduct an updated psychological assessment and to develop an updated behavior support plan. On August 5, 2010 at 3:15 p.m., the record revealed the most current behavior support plan (BSP) was dated October 31, 2009 and a psychological assessment was dated January 6, 2010. At the time of the survey, the updated BSP and psychological assessment had not be provided for review and approval by the GHMRP's human rights committee. At the time of the survey, there was no evidence that services recommended during Resident #2's March 17, 2010 case conference had been coordinated timely by the GHMRP's QMRP, to ensure their implementation for the resident.	I 180	Cross reference W159(c)	8/26/10
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by:	I 401	Cross reference W331	8/19/10

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I 401	Continued From page 7 Based on observation, interview and record review, the GHMRP's nursing services failed to ensure health services as prescribed for one of three residents in the sample.(Resident #3) The finding includes: On August 3, 2010 at 7:35 a.m., Resident #3 was observed to receive Hydrochlorothiazide 12.5 mg, 1 cap. During this time, the resident was initially resistive to having her blood pressure taken by the nurse. With encouragement, however, the resident was able to remain still for her blood pressure (BP) assessment. On August 3, 2010 at 7:39 a.m., interview with the nurse administering the medication revealed that Resident #3's intermittent refusal and/or failure to remain still for blood pressure assessment had been an ongoing concern. The nurse also stated the resident was prescribed a Clonidine Patch, 6.3 mg, to be applied to an area on her body once a week. Additionally, the nurse indicated that the primary care physician (PCP) prescribed that the resident's blood pressure be monitored twice a day. The subsequent review of the resident's record at 8:37 a.m. confirmed the physician's orders for the aforementioned medication. A physician's order dated April 10, 2010, prescribed that Resident #3's blood pressure be assessed and documented twice daily. On August 4, 2010 at 11:42 a.m., record review revealed no blood pressure was documented for Resident #3's at six of the scheduled times in May 2010. Although the previous interview with the nurse had indicated that the resident sometimes failed to remain still and/or refused, there was no evidence the reason why the	I 401		

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I 401	Continued From page 8 resident's blood pressure was not assessed and/or documented on three (May 10, 7, and 13, 2010) of the six dates. The June 2010 MAR revealed a similar finding of no evening BP readings on six days (June 2, 7, 15,16,18, 23 and 24, 2010). At the time of the survey, there was no evidence nursing services had maintained consistent documentation of Resident #3's evening blood pressure readings to ensure accurate monitoring of the effectiveness of her prescribed medications.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP's qualified mental retardation professional (QMRP) failed to ensure resident's received continuous active treatment, for three of the three residents included in the sample. (Residents #1, #2 and #3) The findings include: 1. During medication administration observation on August 4, 2010, at 7:25 a.m., revealed Registered Nurse #1 (RN #1) punched out all of Resident #1's medications from the blister pack. The RN placed the cup of medications into Resident #1's hands in order for the resident to consume the medications with one (1) physical prompt. Further observation revealed the RN poured a cup of water for Resident #1 who then was able to pick up the cup and consume the	I 422	Cross reference W249(2)	8/30/10

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I 422	Continued From page 9 contents with two (2) verbal prompts. During a face-to-face interview with RN #1 on August 4 , 2010, at approximately 7:30 a.m., revealed Resident #1 had a self-medication program however, the program was implemented in the evening. Review of Rresident #1's self-medication program dated August, 2010, on August 4, 2010, at approximately 8:30 a.m., revealed that staff was to document at least three times per week (M-W-F) if the resident was able to perform the following steps during the medication administration. Further review revealed the self-medication program was as follows: a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from blister pack; d. Proper disposal of used medication cup; e. Instill eye drops and f. Put cup in kitchen sink after taking all medications There was no evidence that the resident was given the opportunity to fully participate in the self- medication program. 2. During medication administration observation on August 4, 2010, at 7:55 a.m., revealed RN #1 crushed and mixed Resident #2's medication in applesauce than spoon-fed the cup of medications to resident #2. Further observation revealed the RN poured a cup of water for Resident #2 who then was able to pick up the cup and consume the contents with one (1) verbal prompt.	I 422		

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I 422	Continued From page 10 During a face-to-face interview with RN #1 on August 4 , 2010, at approximately 7:31 a.m., revealed Resident #2 had a self-medication program however, the program was implemented in the evening. Review of Resident #2's self-medication program dated August, 2010, on August 4, 2010, at approximately 8:35 a.m., revealed that staff was to document at least three times per week (M-W-F) if the resident was able to perform the following steps during the medication administration. Further review revealed the self-medication program was as follows: a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from blister pack; d. Take medication with applesauce; e. Put cups in kitchen sink after taking all medications There was no evidence that the resident was given the opportunity to fully participate in the self- medication program. 3. During medication administration observation on August 4, 2010, at 7:35 a.m., revealed RN #1 punched out all of Resident #3's medications from the blister pack. The RN placed the cup of medications into Resident #3's hands in order for the resident to consume the medications with one (1) physical prompt. Further observation revealed the RN poured a cup of water for Resident #3 who then was able to pick up the cup and consume the contents with two (2) verbal prompts.	I 422		

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I 422	Continued From page 11 During a face-to-face interview with RN #1 on August 4 , 2010, at approximately 7:40 a.m., revealed Resident #3 had a self-medication program however, the program was implemented in the evening. Review of Resident #3's self-medication program dated August, 2010, on August 4, 2010, at approximately 8:45 a.m., revealed that staff was to document at least three times per week (M-W-F) if the resident was able to perform the following steps during the medication administration. Further review revealed the self-medication program was as follows: a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from blister pack; d. Proper disposal of used medication cup; f. Put cup in kitchen sink after taking all medications There was no evidence that the resident was given the opportunity to fully participate in the self-medication program. 4. The GHMRP failed to consistently implement strategies identified in resident #1's IPP designed to increase tolerance of her hearing aid during waking hours, as evidenced below: On August 3, 2010, at 10:48 a.m., observation at the day program revealed Resident #1 walked over to the desk where the surveyor was sitting with the day program specialist. The program specialist signed the word [wave] and the resident responding by waving [hi] to the surveyor. The day program specialist signed thank you and	I 422	Cross reference W249.4	9/10/10

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I 422	Continued From page 12 Resident #1 responded by signing thank you back. At 4:07 p.m., evening observations at the home revealed direct care Staff #1 signed the word pretty to Resident #1 and she responded by signing the word pretty back to staff. At approximately 4:10 p.m., the house manager was observed to sign the word wash hands to Resident #1 during snack time. Resident #1 immediately went to the bathroom to wash her hands. On August 3, 2010, at approximately 5:15 p.m., interview with direct care Staff #1 revealed that she signed to Resident #1 because she was deaf. Further interview revealed that Resident #1 had a hearing aid to assist her with hearing. This was also acknowledged through interview with the House Manager on August 4, 2010, at approximately 11:30 a.m. On August 4, 2010, at approximately 9:50 a.m., review of Resident #1's current physician's orders dated July 2010 revealed the resident had a diagnosis of bilateral hearing loss. Interview with the qualified mental retardation professional (QMRP) and review of Resident #1's Individual Support Plan (ISP) dated January 4, 2010 on the same day at approximately 12:15 p.m., revealed an objective for the resident to tolerate her hearing aid during waking hours 100% of trials daily. Observations the previous day (August 3, 2010), however, revealed that Resident #1 was not observed wearing her hearing aid at the day program and at her home. At the time of the survey, there was no evidence that staff implemented Resident #1's program objective (will tolerate her hearing aid) as	I 422		

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I 422	Continued From page 13 required.	I 422		
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for two of the three residents in the sample. (Residents #1 and #3) The finding includes: Review of Resident #1's medical record on August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of the resident's record revealed the resident had full mouth scaling and prophylaxis completed during the dental appointment. Review of Resident #1's Individual Program Plan (IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the resident's oral hygiene. Review of the Qualified Mental Retardation Professionals (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximataly 9:15 a.m., revealed Resident #1's tooth brushing program was being implemented.	I 432	Cross reference W242	8/9/10

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I 432	Continued From page 14 Interview with the QMRP on August 4, 2010, at approximately 9:20 a.m., however revealed Resident #1 did not have a training program to address her dental hygiene. There was no evidence the facility ensured the resident's IPP included training in activities of dental hygiene.	I 432		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each resident and/or their legal guardian to be informed of the resident's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of three residents included in the sample. (Resident #2) The finding includes: During the entrance conference on August 3, 2010, beginning at approximately 8:30 a.m., the qualified mental retardation professional (QMRP) and Residential Manager (RM) indicated that the Resident #2 had sister who assisted with making health care decisions. On August 4, 2010, at approximately 12:20 p.m., review of Resident #2's medical records revealed	I 500	Cross reference W124	8/23/10

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I 500	Continued From page 15 a physician's order dated July 2010, for Ativan 2 mg by mouth one hour prior to her dental appointment. Interview with the QMRP on the same day approximately 12:40 p.m. confirmed that the sedation was given on July 6, 2010. Review of Resident #2's Psychological Assessment dated October 2010, on the August 4, 2010, at approximately 1:20 p.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of Resident #2's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication. At approximately 1:35 p.m., the QMRP acknowledged that she hed not obtained consent from Resident #2's sister prior to the administration of Ativan.	I 500		